

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/15/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445509	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/14/2020
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF OLD HICKORY VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1250 ROBINSON ROAD OLD HICKORY, TN 37138		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X6) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation #TN00050882 was completed on 4/14/2020 at Life Care Center Of Old Hickory Village. Deficiencies were cited related to the complaint investigation #TN00050882 under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000	1.) On April 14, 2020, the DON updated the Care Plan for resident number 1 to reflect current fall interventions.		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657	2.) Beginning on 4/15/2020 and completed on 4/24/20 the DON, ADON and SDC audited previous falls x 3 months to ensure care plans reflected interventions post incidents. 3.) Beginning on 4/15/2020 and completed on 4/28/20, the SDC educated nurses on "Incident Management with an emphasis on updating Care Plans to reflect Interventions". b. Daily, Monday- Friday beginning on 4/20/2020 x 8 weeks, Nurse Management will utilize the "Care Plan Intervention Audit" to ensure Care Plans reflect interventions post fall. After 8 weeks the audits will be completed randomly, monthly. If at any time non-compliance is identified, nurses will be re-educated with progressive discipline as necessary. 4.) Monthly, beginning in May 2020 x 2 months, the QAPI committee will review results of the Care Plan Intervention Audits. If at any time non-compliance is determined the QAPI committee will extend audits until compliance is determined.		4/28/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

RECEIVED
APR 23 2020
Executive Director

(X5) DATE

4/28/20

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting, providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 657	<p>Continued From page 1</p> <p>by:</p> <p>Based on facility policy review, facility documentation, medical record review, and interview the facility failed to revise a comprehensive care plan for 1 of 3 residents (Resident #1) reviewed for falls.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Fall Management dated 4/15/2019 revealed, "...The interdisciplinary team will review and revise the care plan...upon a fall event and as needed thereafter..."</p> <p>Review of the medical record, revealed Resident #1 was admitted to the facility on 11/13/2019 with diagnoses which included Displaced Fracture Of Left Tibia Tuberosity, Fracture of Left Patella, History Of Falling, Reduced Mobility.</p> <p>Review of the medical record, Quarterly Minimum Data Set (MDS) dated 1/24/2020 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14 indicating no cognitive impairment.</p> <p>Review of facility fall documentation dated 3/20/2020 revealed Resident #1 was found on the floor in front of her wheelchair by Certified Nursing Assistant #1.</p> <p>Review of the care plan dated 11/13/2019 revealed no new interventions for Resident #1 related to the fall on 3/20/2020.</p> <p>During an interview conducted on 4/14/2020 at 12:03 PM, the MDS Coordinator confirmed the fall care plan for Resident #1 was not updated to</p>	F 657			4/28/20

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F 657	Continued From page 2 reflect interventions for the fall on 3/20/2020. During an interview conducted on 4/14/2020 at 12:30 PM, the Director of Nursing confirmed the fall care plan for Resident #1 was not updated to reflect new interventions for the fall on 3/20/2020.	F 657		4/28/20	